

454 6/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 44E232	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/04/2016
NAME OF PROVIDER OR SUPPLIER BLEDSON COUNTY NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>This STANDARD is not met as evidenced by: Based on observations and testing, the facility failed to maintain the corridor doors.</p> <p>The finding included:</p> <p>Observation and testing on 5/4/16 at 8:15 AM, revealed the EVS door on the B hall did not close within the frame. National Fire Protection Association NFPA 101; 19.3.6.3 (2000 Edition)</p> <p>This finding was verified by maintenance staff and acknowledged by the administrator during the exit conference on 5/4/16.</p>	K 018	<p>K 018</p> <p>WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>The Environmental Service (EVS) door on B hall was adjusted to close properly by the Maintenance Staff on 5/13/2016.</p> <p>HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN?</p> <p>All residents have the potential to be affected by this practice. Routine monitoring will be conducted by the Maintenance Director & Staff.</p>	5/13/16	
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested</p>	K 062			

K018 - Continued →

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Stephanie Bump

Administrator

5/19/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3</p> <p>This STANDARD is not met as evidenced by: Based on observations and testing, the facility failed to maintain the corridor doors.</p> <p>The finding included:</p> <p>Observation and testing on 5/4/16 at 8:15 AM, revealed the EVS door on the B hall did not close within the frame. National Fire Protection Association NFPA 101, 19.3.6.3 (2000 Edition)</p> <p>This finding was verified by maintenance staff and acknowledged by the administrator during the exit conference on 5/4/16.</p>	K 018	<p>WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>All corridor doors will be checked by Maintenance Staff on a quarterly basis.</p> <p>HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The Maintenance Director will maintain a log that verifies the proper closing of the doors and there will also be a record on file of an annual inspection from a professional contractor.</p>		
K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested</p>	K 062			

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K 062	Continued From page 1 periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the sprinkler system. The findings included: 1. Observation on 5/4/16 at 8:21 AM, revealed painted sprinklers in the patient room closets of 124 and 125. NFPA 101, 19.3.5.1 (2000 Edition), NFPA 101, 9.7.1.1 (2000 Edition), NFPA 13, 12-1 (1999 Edition), NFPA 25, 2-2.1.1 (1998 Edition) 2. Observation on 5/4/16 at 9:00 AM, revealed the spare sprinkler box next to the sprinkler riser did not contain the correct type of sprinklers found throughout the facility. NFPA 101, 19.3.5.1 (2000 Edition), NFPA 101, 9.7.1.1 (2000 Edition), NFPA 13, 3-2.9 (1998 Edition), 3. Observation on 5/4/16 at 9:46 AM, revealed a back canopy constructed of untreated (fire resistive) wood containing large amounts of miscellaneous combustible material without sprinkler protection. (The nursing home roof and the canopy roof were overlapping but not connected.) NFPA 101, 19.3.5.1 (2000 Edition), NFPA 101, 9.7.1.1 (2000 Edition), NFPA 13, 5-13.8.2* (1999 Edition) These findings were verified by maintenance staff and acknowledged by the administrator during the exit conference on 5/4/16 and by the maintenance staff via phone conversation on 5/5/16 at 12:02 PM. NFPA 101 MISCELLANEOUS	K 062	K 062 WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? 1) Painted Sprinklers – The paint was removed from the sprinkler heads in the patient room closets of 124 and 125 by the Maintenance Staff on 5/11/16. 2) Spare Sprinkler Box – The correct type of replacement sprinkler heads were added to the spare sprinkler box next to the sprinkler riser by Maintenance Staff on 5/11/16. 3) Sprinkler at Back Canopy – Maintenance Director received quote from Simplex Grinnell to install sprinkler protection on back canopy. Quote was approved by Administrator and plan will be submitted to State by Simplex Grinnell for approval. Installation of new sprinkler protection will be completed by June 18, 2016, providing State approval and vendor availability. A waiver may be requested at a later date if it appears June 18 is not feasible.	5/11/16 5/11/16 6/18/16	
K 130 SS=D		K 130	K 062 Continued →		

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K 130 SS=D	NFPA 101 MISCELLANEOUS	K 130			

K 062
Continued →

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K 130 SS=D	NFPA 101 MISCELLANEOUS	K 130			

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K 130	<p>Continued From page 2</p> <p>OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: NFPA 101, 4.4.2.1 (2000 Edition)= A prescriptive -based life safety design shall be in accordance with Chapters 1-4, 6-11, and the applicable occupancy Chapters 12-42 of this Code.</p> <p>NFPA 101, 8.2.3.2.1 (2000 Edition)= Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following. (a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies. Exception: The requirement of 8.2.3.2.1(a) shall not apply where otherwise specified by 8.2.3.2.3.1. (b) Fire doors shall be self-closing or automatic-closing in accordance with 7.2.1.8 and, where used within the means of egress, shall comply with the provisions of 7.2.1.</p> <p>NFPA 80, 15-1.2 (1999 Edition) Operability. Doors, shutters, and windows shall be operable at all times. They shall be kept closed and latched or arranged for automatic closing.</p> <p>NFPA 101, 4.4.2.1 (2000 Edition)= A prescriptive -based life safety design shall be in accordance with Chapters 1-4, 6-11, and the applicable occupancy Chapters 12-42 of this Code.</p> <p>NFPA 101, 8.2.3.2.4.2* (2000 Edition)=Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building</p>			K 130	<p>K 130</p> <p>WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE?</p> <p>1) Fire Doors - Maintenance Staff adjusted fire door on B hall to close and latch properly on 5/9/16.</p> <p>2) Penetrations - Penetrations revealed in the mechanical room and DON office were sealed with fire retardant caulk by the Maintenance Staff on 5/9/16.</p> <p>HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN?</p> <p>All residents have the potential to be affected. All fire doors and penetrations in all locations of the facility will be monitored by the Maintenance Staff annually to comply with the Life Safety Standard.</p>		<p>5/9/16</p> <p>5/9/16</p>

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K 130	<p>Continued From page 3</p> <p>service equipment that pass through fire barriers shall be protected as follows:</p> <p>(1) The space between the penetrating item and the fire barrier shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(3) * Insulation and coverings for pipes and ducts shall not pass through the fire barrier unless one of the following conditions is met:</p> <p>a. The material shall be capable of maintaining the fire resistance of the fire barrier.</p> <p>b. The material shall be protected by an approved device that is designed for the specific purpose.</p> <p>(4) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions:</p> <p>a. It shall be made on either side of the fire barrier.</p> <p>b. It shall be made by an approved device that is designed for the specific purpose.</p> <p>Based on observations and testing, the facility failed to comply with the Life Safety Code.</p>	K 130	<p>WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>Maintenance Director will maintain an annual log for monitoring all fire doors and penetrations of the facility.</p> <p>HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>Log sheets will be maintained and reviewed by Safety/Maintenance Director annually to ensure that all fire doors and penetrations in all locations are maintained and comply with the Life Safety Standard.</p>		

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K 130	Continued From page 4 The findings included: 1. Observation and testing on 5/4/16 at 8:41 AM, revealed the B hall fire doors (1 of 2) did not latch within the frame. NFPA 101, 4.4.2.1 (2000 Edition), NFPA 101, 8.2.3.2.1 (2000 Edition), NFPA 80, 15-1.2 (1999 Edition) 2. Observation on 5/4/16 at 9:34 AM, revealed penetrations through the rated assemblies in the following locations: a. The mechanical room (outside) b. The D.O.N office (pipe). NFPA 101, 4.4.2.1 (2000 Edition), NFPA 101, 8.2.3.2.4.2 (2000 Edition) These findings were verified by maintenance staff and acknowledged by the administrator during the exit conference on 5/4/16.	K 130			
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Based on observations and document review, the facility failed to maintain the electrical system. The findings included: 1. Observation on 5/4/16 at 8:09 AM, revealed extension cords in the following rooms: 109, 111, and the activity directors office. NFPA 101, 4.4.2.1 (2000 Edition), NFPA 99, 3-3.2.1.2 (d) 2 (1999 Edition) 2. Observation on 5/4/16 at 8:10 AM, revealed a multiplug adaptor in room 110 (removed by	K 147	K 147 WHAT CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE? 1) Extension cords in rooms 109, 111, and the Activity Directors Office and 2) Multi-plug adaptor in room 110 were removed 5/3/16 by the Maintenance Staff. 3) Use of Power Strips - Maintenance Staff has checked all powerstrips in the facility and has a list with the UL number of each device. This was completed 5/12/16.	5/3/16 5/3/16 5/12/16	

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K 147	<p>Continued From page 5 maintenance). NFPA 101, 4.4.2.1 (2000 Edition), NFPA 99, 3-3.2.1.2 (d) 2 (1999 Edition)</p> <p>3. Observation on 5/4/16 at 8:11 AM, revealed the facility failed to comply with the instructions of CMS S&C letter 14-46 LSC regarding the use of powerstrips as required.</p> <p>4. Document review on 5/4/16 at 10:14 AM, revealed the facility failed to provide documentation for an annual retention force outlet test. NFPA 101, 4.4.2.1 (2000 Edition), NFPA 99, 3-3.3.3.3 (1999 Edition)</p> <p>These findings were verified by maintenance staff and acknowledged by the administrator during the exit conference on 5/4/16.</p>	K 147	<p>4) Retention Force Outlet Test - Maintenance Director has documentation on file of patient care outlets. This was completed by the Maintenance Staff on 5/12/16.</p> <p>HOW WILL YOU IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE AND WHAT CORRECTIVE ACTION WILL BE TAKEN?</p> <p>All residents have the potential to be affected.</p> <p>WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT CHANGES WILL YOU MAKE TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR?</p> <p>A quarterly walk through inspection will be conducted by Maintenance Staff to ensure that all locations of the facility are maintained in accordance with Life Safety Standard. This will also be included as part of the employee orientation.</p> <p>HOW THE CORRECTIVE ACTION(S) WILL BE MONITORED TO ENSURE THE DEFICIENT PRACTICE WILL NOT RECUR?</p> <p>The Maintenance/Safety Director will keep a yearly log sheet on file on the tests of the outlets and the use of the powerstrips to ensure that the electrical wiring and equipment in the facility meets the Fire Safety Standard.</p>	5/12/16	